

TLC DERMATOLOGY MEDICAL CENTER INC

375 SMILE PLACE SUITE B REDDING, CA 96001

530-221-DERM(3376) TLCDERM.COM

LAST NAME FIRST NAME MI BIRTHDATE
SOCIAL SECURITY NUMBER : _____ - _____ - _____ MALE FEMALE DECLINED TO SPECIFY MARITAL STATUS:
 S M D W

CONTACT INFORMATION

MAILING ADDRESS MAY WE LEAVE A DETAILED MESSAGE?
CITY, STATE AND ZIP CODE CELL NUMBER () _____ YES NO
HOME NUMBER () _____ YES NO

PLEASE INDICATE THE FOLLOWING FOR APPOINTMENT REMINDERS

HOME ADDRESS IF DIFFERENT FROM MAILING ADDRESS
ETHNICITY _____ Refused to Report
RACE _____ Refused to Report
LANGUAGE _____
Do you need a translator: YES NO
 TEXTING OR VOICEMAIL

NAME / LOCATION OF PHARMACY _____

EMAIL: If you would like to have access to our patient portal provide your email address.

EMERGENCY & HIPAA RELEASE INFORMATION: PERSONAL HEALTH INFORMATION CAN BE RELEASED TO THE BELOW INDIVIDUAL(S) IF NO DATE STATED THEN NO EXPIRATION WILL BE APPLIED TO NAME GIVEN

NAME	RELATION	PHONE
NAME	RELATION	PHONE

IF YOU HAVE AN ADVANCED DIRECTIVE IN EFFECT, PLEASE PROVIDE THE PERSONS NAME.

NAME _____

RESPONSIBLE PARTY: Self Spouse Parent Please fill out the following if anyone other than yourself

LAST NAME	FIRST NAME	MI	BIRTHDATE
MAILING ADDRESS	SOCIAL SECURITY NUMBER		
CITY, STATE AND ZIP CODE	() CONTACT NUMBER		

PLEASE BRING YOUR INSURANCE CARD TO YOUR VISIT.

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FINANCIAL POLICY

TLC DERMATOLOGY MEDICAL CENTER is committed to providing the highest level of professional medical care and personal service. For every commitment, there is an obligation. Conversely, we feel it is the guardian/patient's responsibility to meet their financial obligation.

As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. While it is our intention to assist you, it is still **your responsibility** to ensure that all services rendered by TLC Dermatology Medical Center, on your behalf, are paid in full. In most instances, TLC DERMATOLOGY MEDICAL CENTER INC. will bill your insurance carrier for you.

For patients whose insurance is provided by a plan with whom we are contracted with we will submit the insurance claim, all co-payments, deductibles, and non-covered services are due at the time of service. If we are contracted with your insurance, we are not able to have you pay cash for services your insurance provider will cover. Any returned checks will be subject to a \$35 processing fee. For any patient who have no insurance or have insurance we are not contracted with payment of services is due on the date of service.

Proof of eligibility for Medicare and contracted insurance companies is the responsibility of the patient. If the insurance carrier reports the patient is not eligible, the patient is responsible for full payment of charges even if litigation is pending. Every effort will be made to bill your insurance company for physician services while in the office. If information provided is incomplete or erroneous, the patient is responsible for full payment or must provide the office with corrected information.

Any unaddressed outstanding balances over 90 days will be sent to a collection agency. Outstanding balances are due at time of visit. If a patient has been sent a balance that has been sent to collections the full amount will be due before the patient can be seen at TLC Dermatology Medical Center.

NO SHOW AND CANCELLATION POLICY

Patients who fail to show for their scheduled appointment or did not notify the office of their cancellation **24 business hours before** their appointment time shall be subject to a \$50 fee. In the event of an actual emergency and prior notice could not be given, consideration will be given and a one-time exception may be granted.

These fees are not billable to insurance and will be the patient's responsibility.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TLC DERMATOLOGY MEDICAL CENTER INC. for any services furnished by that office. I authorize any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

RX CONSENT

I authorize TLC DERMATOLOGY MEDICAL CENTER INC. and the staff to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

GENERAL CONSENT FOR MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended. Multiple treatment of any procedure may occur to reach the desired outcome, each treatment will be billed to both you and your insurance.

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By signing this form, you are consenting for the following treatments that are done in this office. This consent will remain fully effective until revoked in writing.

- I understand that the destruction with liquid nitrogen of actinic keratosis, inflamed seborrheic keratosis, warts and molluscum may be deemed necessary by the provider.
- I understand that the intralesional injection of Kenalog for the treatment of keloids, hypertrophic scars, cysts, acne, psoriasis, atopic dermatitis, and alopecia may be deemed necessary by the provider.
- I understand that any of the above procedures may have some unwanted effects which include but are not limited to permanent scarring, discoloration of the treatment site, infection, atrophy, bleeding, blisters, skin redness and skin thinning.
- I authorize the use and administration of medications and other treatments including the use of cryosurgery with liquid nitrogen, hyfercation, and the injection of Kenalog should these be deemed advisable or necessary for treatment by the provider.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any tests ordered or procedures. If you have any concerns regarding any tests or treatments recommended by the provider, we encourage you to ask questions before treatment is done.

OFFICE VISIT DETAILS

All office visits and additional procedures will be billed to your insurance. We are unable to let you know how much your insurance company will cover and/or pay. If you have any questions regarding insurance payments, please call your insurance provider. At this time most insurances are not covering benign skin lesion removals, such as cysts and lipomas, and will be cash pay.

Any diagnosis, procedures, discussion or even looking at a lesion by the provider will be billed to your insurance.

An office visit includes a skin exam, diagnosis of any skin issues, and/or any medications called in that may be needed for treatment. If any additional procedures are done additional charge(s) will be added to the office visit.

The following procedures are not covered by insurances, they are considered cosmetic and will not be billed to your insurance company. All payment is due at the time of service for the following:

Lasertreatments, Peels, Skin tag removal, Cosmetic Injections (Fillers, Xeomin)

SIGNATURE OF PATIENT: _____ DATE _____

PERSONAL REPRESENTATIVE: _____

TURN OVER TO COMPLETE PATIENT HISTORY

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Name: _____ Date of Birth: _____

Height: _____
Required

Weight: _____
Required

Do you have a pacemaker or defibrillator? Yes No

CURRENT MEDICATIONS:

MEDICATION LIST ATTACHED Yes No

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY: NONE

MEDICATION ALLERGIES: NONE

_____ Side Effect(s) _____
_____ Side Effect(s) _____
_____ Side Effect(s) _____

SURGICAL HISTORY: NONE

HOSPITALIZATIONS: NONE

LIST ANY PERSONAL OR FAMILY HISTORY OF MELANOMA OR SKIN CANCER:

SOCIAL HISTORY:

TOBACCO USE:

NON-SMOKER FORMER SMOKER CURRENT SMOKER _____ PACKS PER DAY FOR _____ YEARS OTHER TOBACCO USE

ALCOHOL USE: NEVER MONTHLY OR LESS 2-4 TIMES A MONTH 2-3 TIMES A WEEK 4 OR MORE TIMES A WEEK

HOW MANY DRINKS DAILY: 1-2 DRINKS 3-4 DRINKS 5-6 DRINKS MORE

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING:

Chills No Yes _____
Fever No Yes _____
Hives No Yes _____
Itching No Yes _____
Rash No Yes _____
Red Eyes No Yes _____
Cold Intolerance No Yes _____
Heat Intolerance No Yes _____

Weakness No Yes _____
Nausea No Yes _____
Easy Bruising No Yes _____
Joint Stiffness No Yes _____
Muscle Aches No Yes _____
Blanching of Skin No Yes _____
Difficulty Walking No Yes _____
Gait Abnormality No Yes _____